Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33675

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8989

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips — Length of stay in 1b: 27	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri b. COUNTY: c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐ d. STREET ADDRESS (If outside, give location): 1040 N. Vandeventer — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Joseph		Jackson	9	24	57

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Negro	Widowed [X]	Jan 11. 1888	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Marchent	None	Ark.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Jackson	Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT / Address
No	—	Wallace Jackson 5215 Lexington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coma

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Coarse Nodular Cirrhosis

DUE TO (c): 581.0

INTERVAL BETWEEN ONSET AND DEATH: undet.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Osteomyelitis of Tibia

19. WAS AUTOPSY PERFORMED? YES ☐ NO [X] 2

20a. ACCIDENT	SUICIDE	HOMICIDE	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
☐	☐	☐	

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 9-10-57 to 9-20-57 and last saw him alive on 9-24-57

Death occurred at 4:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Sidney Fraser, M.D.	2601 Whittier Street	9-25-57

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	9/28/57	Washington Park	St. Louis County Mo

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Boyd Bros	3706 Finney Ave	SEP 26 57	J. Earl Smith, M.D. S.R.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Edward G. Flynn

Licensed Embalmer No. 444

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.